2 Signs and symptoms of psychiatric disorder

In this chapter the symptoms and signs of psychiatric disorders are classified according to the headings of the mental state examination.

DISORDERS OF APPEARANCE AND BEHAVIOUR

General appearance

Self-neglect

Evidence of self-neglect may include:

- A lack of cleanliness in self-care
- Unkempt hair
- Wearing clothes that have not been looked after.

Self-neglect may be consistent with the following psychiatric disorders:

- Dementia
- Psychoactive substance use disorder (of both alcohol and illicit drugs)
- Schizophrenia
- Mood disorder.

Recent weight loss

Evidence of recent weight loss may be provided by poorly fitting clothes that appear too loose. This may result from certain organic disorders, such as carcinoma, and in psychiatric disorders such as depression.

Flamboyant clothing

A patient may be dressed in a colourful, flamboyant way if under the influence of certain psychoactive substances or if suffering from mania.

Russell's sign

This is a very rare sign associated with the presence of calluses on the dorsum of the hands. It may be consistent with a diagnosis of bulimia nervosa, when the patient uses the fingers to stimulate the gag reflex in self-induced vomiting.

Hypothyroidism

This is associated with the following signs, which may be evident from the general appearance (including from the hands on shaking hands with the patient):

- Dry, thin hair (often brittle and unmanageable)
- Facial changes – see below
- Dry skin
- Deafness
- Mild obesity
- Goitre
- Anaemia
- Cold hands.

Hyperthyroidism

This is associated with the following signs, which may be evident from the general appearance (including from the hands on shaking hands with the patient):

- Exophthalmus and other facial changes (see below)
- Goitre
- Tremor
- Weight loss
- Warm hands
- Palmar erythema.

Primary hypoadrenalism (Addison's disease)

This may be associated with:

- Pigmentation of palmar creases and over joints of the hand
- Pigmentation of recent scars
- Dehydration
- Vitiligo
- General wasting
- Weight loss.

Cushing's syndrome

This is associated with the following signs, which may be evident from the general appearance:

- Thin skin
- Facial signs – see below
- 'Buffalo hump'
- Kyphosis
- Bruising
- Oedema
- Striae (unlikely to be visible prior to physical examination).

Facial appearance

Depression

Depressed patients often have:

- Downcast eyes
- A vertical furrow in the forehead
- Downturning of the corners of the mouth.

Mania

Manic patients may look euphoric and/or irritable.

Anxiety

Anxiety in general may be associated with:

- Raised eyebrows
- Widening of the palpebral fissures
- Mydriasis
- The presence of horizontal furrows in the forehead.

Parkinsonism

Relatively fixed unchanging facies may be caused by parkinsonism, which in turn may result from:

- Parkinsonian side effects of antidopaminergic antipsychotic treatment (used in the pharmacotherapy of schizophrenia and mania, for example)
- Parkinson's disease.

Anorexia nervosa

Anorexia nervosa is associated with the presence of fine, downy 'lanugo' hair on the sides of the face (as well as other parts of the body, such as the arms and back, which may not be visible until a physical examination is carried out).

Bulimia nervosa

In bulimia nervosa the face can have a chubby appearance owing to parotid gland enlargement; facial oedema may also occur as a result of purgative abuse. Both are rare.

Hirsutism

Hirsutism in female patients, particularly if accompanied by menstrual disturbances, may result from the following causes:

- Normal hair growth, e.g. in some Mediterranean and south Asian populations
- Polycystic ovary syndrome (the Stein–Leventhal syndrome is a severe form)
- Late-onset congenital adrenal hyperplasia
- Cushing's syndrome
- Virilizing tumours of the ovaries or adrenal glands.

Hypothyroidism

This may be associated with the following signs, which may be evident from the facial (and neck) appearance:

- Dry thin hair (often brittle and unmanageable)
- Loss of eyebrows.
- Dry skin
- Goitre
- Large tongue
- Periorbital oedema
- Anaemia.

Hyperthyroidism

This may be associated with the following signs, which may be evident from the facial (and neck) appearance:

- Exophthalmus
- Goitre
- Lid lag

- Conjunctival oedema
- Ophthalmoplegia.

Primary hypoadrenalism (Addison's disease)

This may be associated with:

- Buccal pigmentation
- Pigmentation of recent scars
- Dehydration
- Vitiligo.

Cushing's syndrome

This may be associated with:

- Moon face
- Acne
- Frontal balding in females
- Hirsutism
- Thin skin
- Bruising.

Posture and movements

Schizophrenia

The following abnormal movements may occur particularly in schizophrenia and sometimes also in other disorders

- *Ambitendency* – the patient makes a series of tentative incomplete movements when expected to carry out a voluntary action (Fig. 2.1)
- *Echopraxia* – the automatic imitation by the patient of another person's movements; it occurs even when the patient is asked not to do it
- *Mannerisms* – repeated involuntary movements that appear to be goal-directed
- *Negativism* – a motiveless resistance to commands and to attempts to be moved
- *Posturing* – the patient adopts an inappropriate or bizarre bodily posture continuously for a long time
- *Stereotypies* – repeated regular fixed patterns of movement (or speech) that are not goal-directed
- *Waxy flexibility* (also known as cerea flexibilitas) – as the examiner moves part of the patient's body there is a

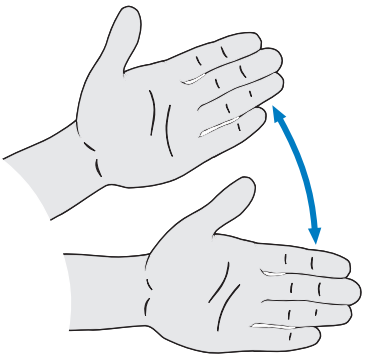

Figure 2.1
An example of ambitendency. In response to the examiner proffering a handshake the patient repeatedly alternates between extending and withdrawing their hand without ever reaching the point of shaking the examiner's hand. (With permission from Puri BK, Laking PJ, Treasaden IH 2002 Textbook of psychiatry. Churchill Livingstone, Edinburgh.)

feeling of plastic resistance (resembling the bending of a soft wax rod) and that part then remains 'moulded' by the examiner in the new position (Fig. 2.2).

Depression

Depressed mood may be associated with poor eye contact, the eyes often being downcast as mentioned above, and hunched shoulders.

Mania

Mania may be associated with increased movements and an inability to sit still. Note that restlessness is also a feature of anxiety and of certain organic disorders (e.g. hyperthyroidism).

Tics

These are repeated irregular movements involving a muscle group. They may be seen in a number of conditions,

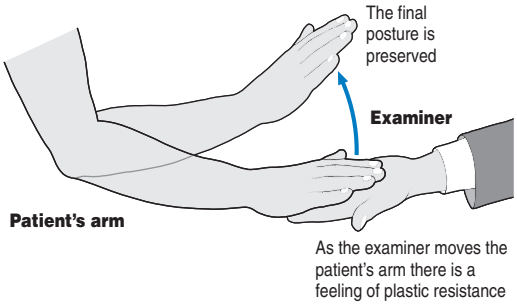

Figure 2.2
Demonstrating waxy flexibility. (With permission from Puri BK, Laking PJ, Treasaden IH 2002 Textbook of psychiatry. Churchill Livingstone, Edinburgh.)

including Huntington's disease, Gilles de la Tourette's syndrome, and following encephalitis.

Parkinsonism

This is associated with a festinant gait.

Underactivity

Stupor

In psychiatry (as opposed to neurology) the term stupor is used to describe a patient who is mute and immobile (akinetic mutism) but fully conscious. (It is known that the patient is fully conscious because sometimes the eyes, which are often open, may follow objects. Moreover, following the episode of stupor the patient may be able to remember events that took place during it.) The condition is sometimes disturbed by periods of excitement and overactivity. Stupor is seen in the following conditions:

- Catatonic stupor
- Depressive stupor
- Manic stupor
- Epilepsy
- Hysteria.

Depressive retardation
This is a form of psychomotor retardation (slowed movements and thinking) occurring in depression that, in its extreme form, merges with depressive stupor.

Obsessional slowness
This refers to slowed movements that may be secondary to repeated doubts and compulsive rituals.

Overactivity

Psychomotor agitation
There is excess overactivity, which is usually unproductive, and restlessness.

Hyperkinesis
There is overactivity, distractibility, impulsivity and excitability. It is seen particularly in children and adolescents.

Somnambulism
In this condition (also known as sleep walking) a person who rises from sleep and is not fully aware of the surroundings carries out a complex sequence of behaviours.

Compulsion
This is a repetitive and stereotyped seemingly purposeful behaviour. It is also referred to as a compulsive ritual and is the motor component of an obsessional thought. Examples of compulsions include:

- Checking rituals, in which the patient may repeatedly check that the front door is closed or that electrical switches are in the 'off' position, for example
- Cleaning rituals, in which the patient may repeatedly wash his/her hands, sometimes even to the point that the skin is damaged
- Counting rituals
- Dressing rituals
- Dipsomania: a compulsion to drink alcohol
- Polydipsia: a compulsion to drink water
- Kleptomania: a compulsion to steal
- Trichotillomania : a compulsion to pull out one's hair

- Satyriasis: a compulsive need in the male to engage in sexual intercourse
- Nymphomania: a compulsive need in the female to engage in sexual intercourse.

Social behaviour

Dementia

The patient may not act according to accepted conventions, for example by ignoring the interviewer.

Schizophrenia

The patient may act in a bizarre, aggressive or suspicious manner.

Mania

The patient may flirt with the interviewer and be sexually or otherwise disinhibited.

DISORDERS OF SPEECH

Disorders of rate and quantity

Increased rate

The rate of speech may be increased in mania.

Decreased rate

The rate of speech may be decreased in:

- Dementia
- Depression.

Increased quantity

The quantity of speech may be increased in:

- Mania
- Anxiety.

Decreased quantity

The quantity of speech may be decreased in:

- Dementia
- Schizophrenia
- Depression.

Pressure of speech
The speech is increased in both quantity and rate and is difficult to interrupt.

Logorrhoea (volubility)
The speech is fluent and rambling, with the use of many words.

Poverty of speech
The speech is markedly reduced in quantity, with perhaps only occasional monosyllabic replies to questions.

Mutism
Total loss of speech occurs.

Dysarthria
This is difficulty in the articulation of speech.

Dysprosody
This is the loss of the normal melody of speech.

Stammering
Pauses and the repetition of parts of words break the flow of speech.

Disorders of the form of speech

Flight of ideas
The speech consists of a stream of accelerated thoughts with abrupt changes between topics and no central direction. The connections between thoughts may be based on:

- Chance relationships
- Verbal associations, e.g. alliteration and assonance
- Clang associations (using words with a similar sound) and punning (using the same word with more than one meaning)
- Distracting stimuli.

Circumstantiality
Speech indicates slowed thinking incorporating unnecessary trivial details. The goal of thought is finally, but slowly, reached, as shown in Figure 2.3.

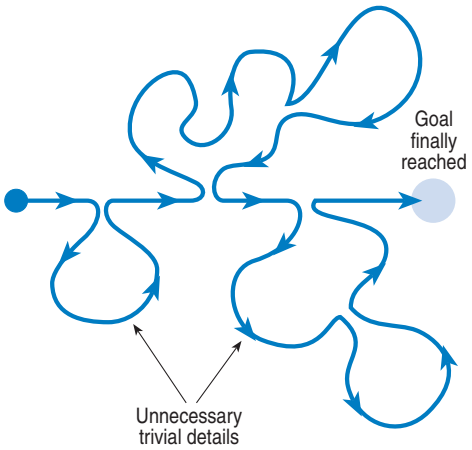

Figure 2.3
Diagrammatic representation of circumstantiality, showing how the goal of the thoughts is finally reached. (With permission from Puri BK, Laking PJ, Treasaden IH 2002 Textbook of psychiatry. Churchill Livingstone, Edinburgh.)

Passing by the point (vorbeigehen)
The answers to questions, although obviously wrong, show that the questions have been understood. For example, if asked 'What colour is grass?', the patient may answer 'Blue'. This disorder is seen in Ganser's syndrome, first described in criminals awaiting trial.

Talking past the point (vorbeireden)
The point of what is being said is never quite reached.

Neologism
A word is newly made up, or an everyday word is used in a special way.

Perseveration (of speech and movement)
Mental operations carry on beyond the point at which they are appropriate.

- *Palilalia* – a word is repeated with increasing frequency
- *Logoclonia* – the last syllable of the last word is repeated.

Echolalia
Another's speech is automatically imitated.

Thought blocking
A sudden interruption in the train of thought occurs, leaving a 'blank', after which what was being said cannot be recalled.

Disorders (loosening) of association (formal thought disorder)
This is a language disorder seen in schizophrenia. For example:

- *Knight's move thinking* – odd, tangential associations between ideas lead to disruptions in the smooth continuity of speech.
- *Word salad (schizophasia or speech confusion)* – the speech is an incoherent and incomprehensible mix of words and phrases.

DISORDERS OF EMOTION

Affect

Affect is a pattern of observable behaviours that expresses a subjectively experienced feeling state (emotion) and is variable over time in response to changing emotional states (DSM-IV-TR). It may be abnormal by being inappropriate, blunted, flat or labile. For example, if a man appears cheerful immediately following the death of a loved one his affect is inappropriate. A reduction in emotional expression occurs if the affect is blunted. If the affect is flat there is almost no emotional expression at all, and the patient typically has an immobile face and monotonous voice. A person's affect is labile if it repeatedly and rapidly shifts, for example from sadness to anger.

Inappropriate affect
This is an affect that is inappropriate to the thought or speech it accompanies.

Blunted affect
Here the externalized feeling tone is severely reduced.

Flat affect
This consists of a total or almost total absence of signs of expression of affect.

Labile affect
There is a labile externalized feeling tone which is not related to environmental stimuli.

Mood

Mood is a pervasive and sustained emotion that, in the extreme, markedly colours the person's perception of the world (DSM-IV-TR).

Dysphoria
This is an unpleasant mood.

Depression
This is a low or depressed mood that may be accompanied by **anhedonia**, in which the ability to enjoy regular and pleasurable activities is lost. In normal **grief** or mourning the sadness is appropriate to the loss.

Elevated mood
This is a mood more cheerful than normal. It is not necessarily pathological.

Expansive mood
Feelings are expressed without restraint, and self-importance may be overrated.

Euphoric mood
This is an exaggerated feeling of wellbeing. It is pathological.

Ecstasy
This is a feeling of intense rapture.

Irritability
This is a liability to outbursts or a state of reduced control over aggressive impulses towards others. It may be a trait of

personality or it may accompany anxiety. It also occurs during the premenstrual syndrome.

Alexithymia

This is difficulty in being aware of or describing one's emotions.

Others

Agitation

This is excessive motor activity with a feeling of inner tension.

Ambivalence

This is the simultaneous presence of opposing impulses towards the same thing.

Anxiety

This is a feeling of apprehension or tension caused by anticipating an external or internal danger, for example:

- *Phobic anxiety* – the focus of anxiety is avoided
- *Free-floating anxiety* – pervasive and unfocused anxiety
- *Panic attacks* – acute, episodic, intense anxiety attacks with or without physiological symptoms.

Fear

This is anxiety caused by a recognized real danger.

Tension

This is an unpleasant increase in psychomotor activity.

Apathy

This is detachment or indifference and a loss of emotional tone and the ability to feel pleasure.

DISORDERS OF THOUGHT CONTENT

These are concerned with the contents of the subject's thoughts as opposed to how the thoughts are put together (form of thought).

Obsession

Repetitive, senseless thoughts are recognized as being irrational by the patient and, at least initially, are unsuccessfully resisted. Themes include:

- Fear of causing harm
- Dirt and contamination
- Aggression
- Sexual
- Religious, e.g. a religious person may have distressing recurrent blasphemous thoughts.

Phobia

A phobia is a persistent irrational fear of an activity, object or situation leading to avoidance. The fear is out of proportion to the real danger and cannot be reasoned away, being out of voluntary control. Important groups of phobias include:

- *Simple phobia*, e.g. a fear of spiders
- *Social phobia* – a fear of personal interactions in a public setting, such as public speaking, eating in public, and meeting people
- *Agoraphobia* – literally 'a fear of the marketplace', this is a syndrome with a generalized high anxiety level and multiple phobic symptoms; it may include fears of crowds, open and closed spaces, shopping, social situations and travelling by bus or train.

Hypochondriasis

Hypochondriasis refers to a preoccupation, not based on real organic pathology, with a fear of having a serious physical illness. Physical sensations are unrealistically interpreted as being abnormal.

ABNORMAL BELIEFS AND INTERPRETATION OF EVENTS

Overvalued idea

An unreasonable and sustained intense preoccupation maintained with less than delusional intensity is described as an

overvalued idea. The belief is demonstrably false and not one normally held by others of the same subculture. There is a marked associated emotional investment.

Delusion

A delusion is a false personal belief based on incorrect inferences about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one normally held by others of the same subculture (DSM-IV). Delusions can be mood-congruent or mood-incongruent. Passivity phenomena are described below. Some other important types of delusions are shown in Table 2.1.

Primary delusion

A primary delusion arises fully formed without any discernible connection with previous events. It may be preceded by a **delusional mood**, in which there is an awareness of something unusual and threatening occurring.

Passivity phenomena

These are delusional beliefs that an external agency is controlling aspects of the self that are normally entirely under one's own control. Such aspects include:

- Thoughts (**thought alienation**) – the patient believes that his/her thoughts are under the control of an outside agency or that others are participating in his/her thinking
- Feelings (**made feelings**) – the patient may feel that his/her own feelings have been removed and that an external agency is controlling them
- Will (**made impulses**) – the patient may feel that his/her own free will has been removed and that an external agency is controlling his/her impulses
- Actions (**made actions** (**made acts**)) – the patient may feel that his/her own free will has been removed and that an external agency is controlling his/her actions
- Sensations (**somatic passivity**) – the patient has the feeling that s/he is a passive recipient of somatic or bodily sensations from an external agency.

Table 2.1 Types of delusion

Type of delusion	Delusional belief
Persecutory (querulant delusion)	One is being persecuted
Of poverty	One is in poverty
Of reference	The behaviour of others, and objects and events such as television and radio broadcasts and newspaper reports, refer to oneself in particular; when similar thoughts are held with less than delusional intensity they are called ideas of reference
Of self-accusation	One's guilt
Erotomania (de Clérambault's syndrome)	Another person is deeply in love with one (usually occurs in women with the object often being a man of much higher social status)
Of infidelity (pathological jealousy, delusional jealousy, Othello syndrome)	One's spouse or lover is being unfaithful
Of grandeur	Exaggerated belief of one's own power and importance
Of doubles (l'illusion de sosies, seen in Capgras's syndrome)	A person known to the patient has been replaced by a double
Fregoli's syndrome	A familiar person has taken on different appearances and is recognized in other people
Nihilistic	Others, oneself or the world do not exist or are about to cease to exist
Somatic	Delusional belief pertaining to the functioning of one's body
Bizarre	Belief is totally implausible and bizarre
Systematized	A group of delusions united by a single theme or a delusion with multiple elaborations

Important types of thought alienation include:

- **Thought insertion** – the patient believes that thoughts are being put into his/her mind by an external agency
- **Thought withdrawal** – the patient believes that thoughts are being removed from his/her mind by an external agency
- **Thought broadcasting** – the patient believes that his/her thoughts are being 'read' by others, as if they were being broadcast.

Delusional perception

A new and delusional significance is attached to a familiar real perception without any logical reason.

ABNORMAL EXPERIENCES

Sensory distortions

Changes in intensity

Sensations may appear increased (**hyperaesthesia**) or decreased (**hypoaesthesia**). Hyperacusis is an increased sensitivity to sounds.

Changes in quality

In the case of visual stimuli this may cause **visual distortions**. When perceptions are coloured, for example because of toxins or retinal damage, they are named after the colours, such as:

- Chloropsia – green
- Erythropsia – red
- Xanthopsia – yellow.

Changes in spatial form

In **macropsia** objects appear larger or nearer, whereas in **micropsia** they appear smaller or further away.

Sensory deceptions

Illusion

An illusion is a false perception of a real external stimulus.

Hallucination

This is a false sensory perception occurring in the absence of a real external stimulus. It is perceived as being located in objective space and as having the same realistic qualities as normal perceptions. It is not subject to conscious manipulation and indicates a psychotic disturbance only when there is also impaired reality testing. Hallucinations can be mood-congruent or mood-incongruent. They can be classified as being elementary (e.g. bangs and whistles) or complex (e.g.

hearing a voice, musical hallucinations, seeing a face). Modalities in which hallucinations may occur include:

- *Auditory* – these may occur in depression (particularly second-person hallucinations of a derogative nature), in schizophrenia (particularly third-person hallucinations and running commentaries), and as a result of organic disorders (e.g. complex partial seizures of the temporal lobe) and psychoactive substance use (e.g. alcoholic hallucinosis and following the use of amphetamines)
- *Visual* – these are particularly indicative of organic disorders
- *Olfactory*
- *Gustatory*
- *Somatic* – these include:
  - Tactile hallucinations (also known as haptic hallucinations), which are superficial and usually involve sensations on or just under the skin in the absence of a real stimulus; these include the sensation of insects crawling under the skin (called **formication**)
  - Visceral hallucinations of deep sensations.

Other special types of hallucination include:

- *Hallucinosis* – hallucinations (usually auditory) occur in clear consciousness, usually as a result of chronic alcohol abuse
- *Reflex* – a stimulus in one sensory field leads to an hallucination in another sensory field
- *Functional* – the stimulus causing the hallucination is experienced in addition to the hallucination itself
- *Autoscopy* (also called the *phantom mirror image*) – the patient sees him/herself and knows that it is her/him
- *Extracampine* – the hallucination occurs outside the patient's sensory field
- *Trailing phenomenon* – moving objects are seen as a series of discrete discontinuous images, usually as a result of taking hallucinogens
- *Hypnopompic* – the hallucination (usually visual or auditory) occurs while waking from sleep; it can occur in normal people
- *Hypnagogic* – the hallucination (usually visual or auditory) occurs while falling asleep; it can occur in normal people.

Pseudohallucination

This is a form of imagery arising in the subjective inner space of the mind and lacking the substantiality of normal perceptions. It is not subject to conscious manipulation.

Disorders of self-awareness (ego disorders)

These include **depersonalization**, in which the subject feels altered or not real in some way, and **derealization**, in which the surroundings do not seem real. Both may occur in normal people (e.g. when tired).

COGNITIVE DISORDERS

Disorders of attention

Distractibility

Here the patient's attention is drawn too frequently to unimportant or irrelevant external stimuli.

Selective inattention

Here the patient blocks out anxiety-provoking stimuli.

Disorders of memory

Amnesia

This is the inability to recall past experiences.

Hypermnesia

In hypermnesia the degree of retention and recall is exaggerated.

Paramnesias

This is a distorted recall leading to falsification of memory. Paramnesias include:

- *Confabulation* – gaps in memory are unconsciously filled with false memories, as occurs in the amnesic (or Korsakov's) syndrome
- *Déjà vu* – the subject feels that the current situation has been seen or experienced before
- *Déjà entendu* – the illusion of auditory recognition

- *Déjà pensé* – the illusion of recognition of a new thought
- *Jamais vu* – failure to recognize a familiar situation
- *Retrospective falsification* – false details are added to the recollection of an otherwise real memory.

Disorders of intelligence

Learning disability (mental retardation)

DSM-IV-TR and ICD-10 classify this according to the intelligence quotient (IQ):

- IQ 50–70: mild mental retardation
- IQ 35–49: moderate mental retardation
- IQ 20–34: severe mental retardation
- IQ < 20: profound mental retardation.

Dementia

This refers to a global organic impairment of intellectual functioning without impairment of consciousness (Ch. 3).

Pseudodementia

This is similar clinically to dementia but has a non-organic cause, for example depression.

Disorders of consciousness

These include, progressively, somnolence, stupor, semi coma and coma, described in Chapter 1; the term stupor is used here in its neurological rather than its psychiatric sense.

Clouding of consciousness

The patient is drowsy and does not react completely to stimuli. There is disturbance of attention, concentration, memory, orientation and thinking.

Delirium

The patient is bewildered, disorientated and restless. There may be associated fear and hallucinations (Ch. 3).

Fugue

This is a state of wandering from the usual surroundings and loss of memory.

Aphasias

See also Chapter 1.

Receptive (sensory) aphasia

Difficulty is experienced in comprehending word meanings, for example:

- *Agnosic alexia* – words can be seen but not read
- *Pure word deafness* – words that are heard cannot be comprehended
- *Visual asymbolia* – words can be transcribed but not read.

Intermediate aphasia

This includes:

- *Nominal aphasia* – difficulty in naming objects
- *Central (syntactical) aphasia* – difficulty in arranging words in their correct sequence.

Expressive (motor) aphasia

Difficulty is experienced in expressing thoughts in words but comprehension remains.

Global aphasia

Both receptive and expressive aphasia are present at the same time.

Jargon aphasia

This is incoherent, meaningless, neologistic speech.

Agnosias and disorders of body image

Agnosia is to an inability to interpret and recognize the significance of sensory information, which does *not* result from:

- Impairment of the sensory pathways
- Mental deterioration
- Disorders of consciousness
- Attention disorder
- (In the case of an object) a lack of familiarity with the object.

Visuospatial agnosia
This is similar to **constructional apraxia** (Ch. 1).

Visual (object) agnosia
Here a familiar object that can be seen but not recognized by sight can be recognized through another modality such as touch or hearing.

Prosopagnosia
This is an inability to recognize faces. In extreme cases the patient may be unable to recognize his/her own reflection in the mirror. For example, in advanced Alzheimer's disease a patient may misidentify his/her own mirrored reflection, a phenomenon known as the **mirror sign**.

Agnosia for colours
Here the patient is unable to name colours correctly, although colour sense is still present.

Simultanagnosia
Here the patient is unable to recognize the overall meaning of a picture, although its individual details are understood.

Agraphognosia or agraphaesthesia
Here the patient is unable correctly to identify, with closed eyes, numbers or letters traced on his/her palm.

Anosognosia
Here there is a lack of awareness of disease, particularly of hemiplegia (most often following a right parietal lesion).

Coenaesthopathic state
This term refers to a localized distortion of body awareness.

Autotopagnosia
This is the inability to name, recognize or point on command to parts of the body.

Astereognosia
In this disorder, objects cannot be recognized by palpation.

Finger agnosia
Here the patient is unable to recognize individual fingers, be they his/her own or those of another person.

Topographical disorientation
Here the patient shows evidence of disorientation on attempting to carry out a task that entails topographical orientation, such as one involving map-reading.

Distorted awareness of size and shape
Here, a limb may be felt to be growing larger.

Hemisomatognosis or hemidepersonalization
Here the patient feels that a limb (which in fact is present) is missing.

Phantom limb
This refers to the continued awareness of the presence of a limb after that limb has been removed.

Reduplication phenomenon
Here the patient feels that part or all of the body has been duplicated.

DYNAMIC PSYCHOPATHOLOGY

Dynamic psychopathology is based on the work of Sigmund Freud and postulates a mental structure made up of the id, the ego and the superego.

Mental apparatus

The mental apparatus is a relatively stable psychological organization within the individual that is involved in both behaviour and subjective experience (such as dreams).

Id
The id is an unconscious part of the mental apparatus that is made up partly of inherited instincts and partly of acquired, but repressed, components.

Ego
The ego is present at the interface of the perceptual and internal demand systems. It controls voluntary thoughts and actions and, at an unconscious level, defence mechanisms.

Superego
The superego is a derivative of the ego that exercises self-judgement and holds ethical and moralistic values.

The unconscious

The unconscious can be studied using the following:

- *Free association* – the articulation, without censorship, of all thoughts that come to mind is encouraged
- *Freudian slips (parapraxes)* – unconscious thoughts slip through when censorship is off-guard
- *Dreams analysis* – dreams may be based on the subject's unconscious wishes.

Transference and countertransference

Transference
This is the unconscious process whereby emotions and attitudes experienced in childhood are transferred to the therapist.

Countertransference
This describes the therapist's emotions and attitudes to the patient

Defence mechanisms

These protect the consciousness from the affects, ideas and desires of the unconscious.

Denial
The subject acts as if consciously unaware of a wish or reality.

Displacement
Thoughts and feelings about one person or object are transferred to another person or object.

Introjection and identification
The attitudes and behaviour of another person are transposed into the subject, helping the latter cope with separation from that person.

Isolation
Certain thoughts are isolated from others.

Projection
Repressed thoughts and wishes are attributed to other people or objects.

Projective identification
Another person is seen as both possessing and constrained to take on repressed aspects of the subject's self.

Rationalization
An attempt is made to explain, in a logically consistent or ethically acceptable way, affects, ideas and wishes the true motive of which is not consciously perceived.

Reaction formation
A psychological attitude is held that is diametrically opposed to an oppressed wish.

Regression
There is a return to an earlier stage of development.

Repression
Unacceptable affects, ideas and wishes are pushed away so that they remain in the unconscious.

Sublimation
Unconscious wishes are allowed to be satisfied by means of socially acceptable activities.

Undoing (what has been done)
The subject attempts to cause previous thoughts or actions not to have occurred.